

Allergy & Asthma Treatment Center  
292 S Broadway St., Suite 1, Lake Orion, MI 48362  
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Date Filled: \_\_\_\_\_

## ALLERGY-IMMUNOLOGY HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please take your time to complete all 4 pages as applicable to your case.

Patient Name: \_\_\_\_\_  M  F \_\_\_\_\_ DOB  
(Last, First, M.I.) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Who is filling this questionnaire? Self Father Mother Other:

Marital Status:  Single  Partnered  Married  Separated  Divorced  Widowed

Please state the main reasons for this visit:

Primary care physician: \_\_\_\_\_ How did you find out about us? \_\_\_\_\_

### PERSONAL HEALTH HISTORY

Childhood Illness:  Measles  Mumps  Rubella  Chickenpox  Rheumatic Fever

Immunizations: Any reactions to vaccines you have received?  
Are immunizations up to date?

List Any Medical Problems that other Doctors have diagnosed:

Have you ever been evaluated for allergies (ie, skin tests)  Yes  No  
If yes, please provide the results if available to you:

Were you treated with allergy shots?  Yes  No If Yes, for how long?

Did you miss any days from school or work in the last year because of your allergy or asthma symptoms?  
 Yes  No If Yes, how many? \_\_\_\_\_

Did you have any surgeries?

Other Hospitalizations:

List Allergies or other adverse reactions to Medications? Name the drug and describe the reaction:



<b>Nasal and sinus symptoms:</b>	<p><b>Do you have any of the following? Check answer.</b>  <b>If Yes, mark an X for mild, XX for moderate and XXX for severe</b></p> <p><b>Itchy nose:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes:                      <b>Runny nose:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes:  <b>Sneezing:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes:                                      <b>Congestion:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes:  <b>Mouth breathing:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes:                              <b>Snoring:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes:  <b>Post-nasal drip:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes:                              <b>Frontal or sinus headaches:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes:  <b>Nose bleeding:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes:                              <b>Itchy, sore or scratchy throat:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes:  <b>Frequent clearing of the throat:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes:</p> <p><b>Any known trigger for the above symptoms, such as:</b> (check all that apply)</p> <p><input type="checkbox"/> House dust              <input type="checkbox"/> Pet (dog, cat, etcí )              <input type="checkbox"/> Playing in or cutting the grass              <input type="checkbox"/> Hay  <input type="checkbox"/> Playing around trees              <input type="checkbox"/> Raking leaves              <input type="checkbox"/> Cold weather              <input type="checkbox"/> Weather changes  <input type="checkbox"/> Temperatures changes              <input type="checkbox"/> looking at the sun              <input type="checkbox"/> Moldy/mildew area (humid basement)  <input type="checkbox"/> Strong smells (perfumes, sprays)              <input type="checkbox"/> Cleaning agents              <input type="checkbox"/> Smoking, smog or smoke exposure  <input type="checkbox"/> Alcoholic beverages, specify:  <input type="checkbox"/> Aspirin and other pain killers, specify:                      <input type="checkbox"/> Others, please specify:  <input type="checkbox"/> Foods, specify:</p>
<b>Breathing Symptoms:</b>	<p>Do you experience any of the following:</p> <p><b>Deep cough:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes. If Yes, what time of the year?  <b>Wheezing:</b> <input type="checkbox"/>No <input type="checkbox"/>Yes. If Yes, what time of the year?  <input type="checkbox"/>Yes, with colds or viral infections</p> <p>If you answered Yes, are your symptoms noted? (Check what applies)</p> <p><b>Several times a Day</b> <input type="checkbox"/>                              <b>Three to five days a week</b> <input type="checkbox"/>  <b>One or two days a week</b> <input type="checkbox"/>              <b>Once or twice a month</b> <input type="checkbox"/>              <b>Rarely: once every 3-4 months</b> <input type="checkbox"/></p> <p><b>Night symptoms:</b> <input type="checkbox"/>No              <input type="checkbox"/>Yes, if yes how frequently? í í í í í</p>
<b>Exercise-induced Symptoms:</b>	<p><b>How would you describe your activity level? (check one)</b></p> <p><input type="checkbox"/> Sedentary (No exercise)              <input type="checkbox"/> Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)  <input type="checkbox"/> Occasional Vigorous Exercise (work or recreation, less than 4 times/week for 30 min.)  <input type="checkbox"/> Regular Vigorous Exercise (work or recreation 4 times/week for 30 minutes or more)</p> <p><b>When exercising, do you experience any of the following?</b></p> <p>1- <b>Cough</b>                      <input type="checkbox"/> Yes, always              <input type="checkbox"/> Yes, sometimes              <input type="checkbox"/> No  2- <b>Wheezing</b>                      <input type="checkbox"/> Yes, always              <input type="checkbox"/> Yes, sometimes              <input type="checkbox"/> No  3- <b>Chest tightness</b>                      <input type="checkbox"/> Yes, always              <input type="checkbox"/> Yes, sometimes              <input type="checkbox"/> No  4- <b>Shortness of breath preventing you from keeping up with others</b>              <input type="checkbox"/> Yes              <input type="checkbox"/> No</p>
<b>Tobacco:</b>	<p><b>1- Tobacco use?</b> <input type="checkbox"/> Yes    <input type="checkbox"/> No <input type="checkbox"/> Cigarettes - Packs/day _____ <input type="checkbox"/> Pipe              <input type="checkbox"/> Cigars  Number of Years smoked _____ Year Quit, if apply _____</p> <p><b>2- Second hand exposure to cigarette smoke?</b> <input type="checkbox"/> Yes    <input type="checkbox"/> No If yes. Where?</p>
<b>Lung infections:</b>	<p>History of pneumonia? <input type="checkbox"/> Yes    <input type="checkbox"/> No  History of bronchitis? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<b>Gastro-intestinal Symptoms:</b>	<p><b>Reflux Disease:</b> Do you suffer from <b>heartburn</b>? <input type="checkbox"/> Yes    <input type="checkbox"/> No  If patient is a child, any problems with vomiting or frequent regurgitation? <input type="checkbox"/> Yes    <input type="checkbox"/> No  Any complaint of abdominal pain? <input type="checkbox"/> Yes    <input type="checkbox"/> No  Any complaint of diarrhea or loose stools? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>

